Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare North Dallas

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-13-1577-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of services 8/31/12, 9/27/12 and 10/26/12 were office visits and work status reports. The work status report was paid, but not the office visit. I resubmitted letting them know the time take to fill out and meet with the patient for work status reports, require an office visit… I have attached all necessary documentation."

Amount in Dispute: $680.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received March 4, 2013. However no written position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2012 September 24, 2012 September 27, 2012 Octob34 26, 2012 November 28, 2012	99213 99214 99213 99213 99214	$680.49	$169.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the requirements ot medical documentation
3. 28 Texas Administrative Code §134.203 sets out guidelines for professional fee reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - LN – This line was included in the reconsideration of this previously reviewed bill.

- B1 – Services not documented in patients' medical record.
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 16 – Claim/service lacks information which is needed for adjudication.

Issues

1. Did the requestor support services billed with medical documentation?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor states, "I have attached all necessary documentation." 28 Texas Administrative Code §133.210(c)(1) states in pertinent part, "(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;…" Review of the submitted documentation finds only date of service 11/23/2012 is supported by a medical record. Therefore, this date of service will be reviewed per applicable rules and guidelines. The other dates of service cannot be reviewed per requirements of Rule 133.210
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the service in dispute. For services in 2012, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price or;

Dates of Service	Submitted Code	MAR	Amount Due
August 31, 2012	99213	Not supported by medical record	n/a
September 24, 2012	99214	Not supported by medical record	n/a
September 27, 2012	99213	Not supported by medical record Not supported by medical record	n/a
October 26, 2012	99213	Not supported by medical record	n/a
November 28, 2012	99214	(66.88 / 34.0376) x $104.89 = $169.06	$169.06
	Total	$169.06	$169.06

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $169.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $169.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June16, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.